Developing an Alternative Strategy for Achieving Health for All

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he ICSSR/ICMR Model- The FRCH Experience

Noshir Antia
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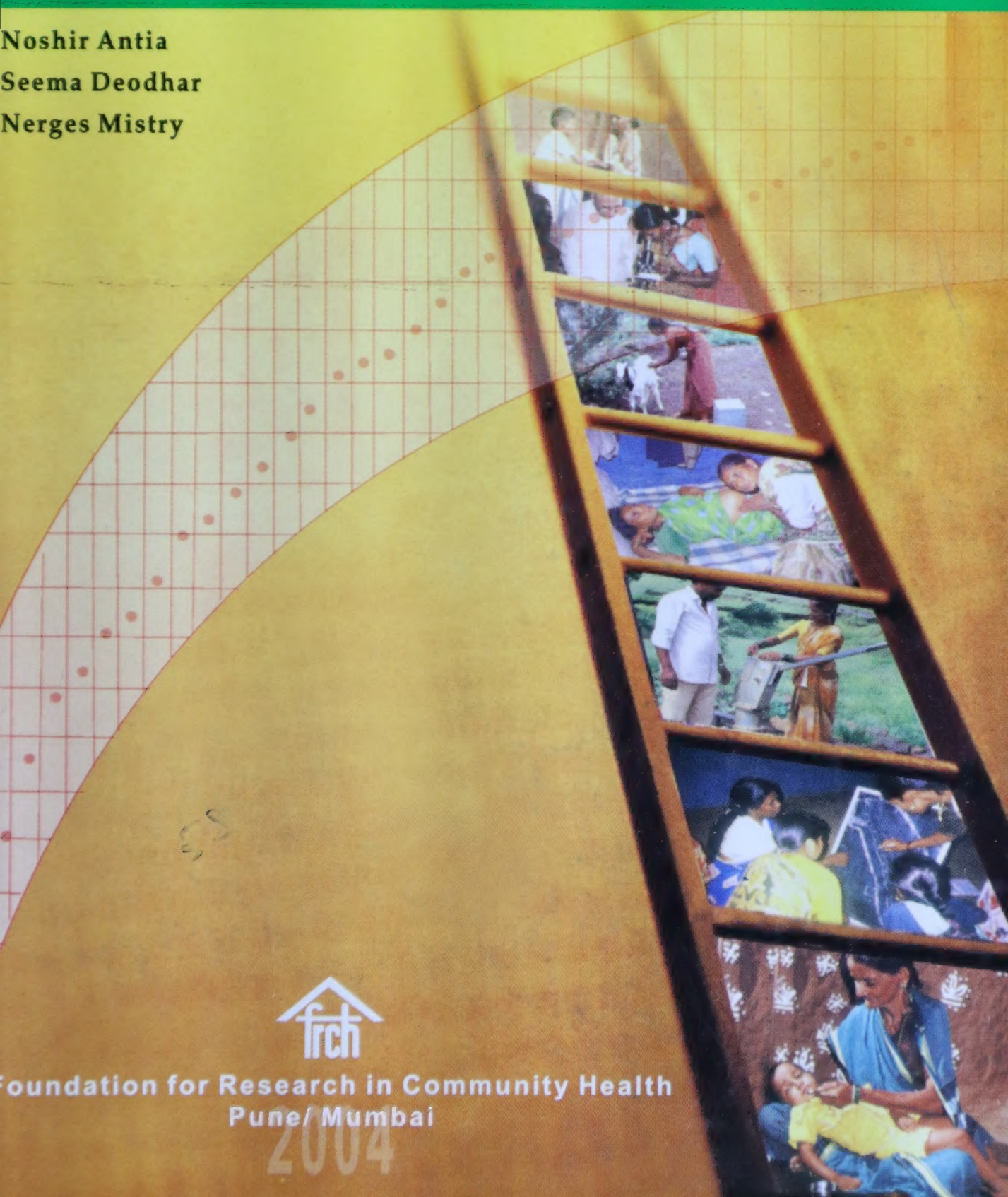

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About FRCH

The Foundation was established in 1975 as a non-profit voluntary organisation to promote the concept of health care rather than the mere care of illness. This entails the study of health in its wider perspective in order to improve the health of our people. The emphasis is on the problems of the underprivileged sections of our society, especially women and children.

Our staff from various disciplines are engaged in conducting both conceptual research as well as field studies into the problems faced in achieving Health for All. This is to help in devising alternate models of health and medical care in keeping with the social, economic and cultural reality of the country. The aim is to influence government policy and sensitize the people at all levels to the problems and possibility of achieving good health at affordable cost.

FRCH believes that health is a reflection of the overall quality of life: In fact, 80 percent of the diseases in India are the diseases of poverty and true health can exist only when there is a positive improvement in the socio-economic scenario of the country. This can only be achieved through the people's own efforts. Hence, FRCH aims to create a People's Health Movement by demystifying medicine and increasing public awareness on health, especially at the grassroots level, and by strengthening the age old health culture of our people based on our own systems of health and medical care. This is to be achieved, by publishing and disseminating information on all aspects of health and related subjects, and also by conducting participatory training and interacting with the community.

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Their foresight in supporting this lateral concept of a people based form of health care in its early stages has provided strength and confidence to our work. The personal participation of Shri Naoroji P. Godrej, FRCH, Trustee and visionary industrialist in the development of the Mandwa Project is especially remembered.

Abbreviations

ANM	Auxiliary Nurse Midwife(ves)
AVI	Accredited Vocational Institute
CHC	Community Health Centre
CHCS	Community Health Care System
DOTS	Directly Observed Treatment, Short Course
FRCH	Foundation for Research in Community Health
GDP	Gross Domestic Product
ICSSR	Indian Council of Social Science and Research
ICMR	Indian Council of Medical Research
MCH	Maternal and Child Health
NGO	Non Governmental Organization
NIOS	National Institute of Open Schooling
PHC	Primary Health Centre
PRI	Panchayati Raj Institution(s)
RCH	Reproductive and Child Health
RNTCP	Revised National Tuberculosis Control Programme
SYMPMED	Symptomatic Medicine
TB	Tuberculosis
VHF	Village Health Functionary
WHO	World Health Organization

Glossary of Indian Terms

Ayurveda	Alternative system of medicine derived from or modified in and practised in India.
Bharat	Another name for India
Dharmashala	Temporary staying arrangements in the proximity of the People's Hospital in the CHCS for patients and relatives for which token payment is accepted.
Gram Panchayat	Executive council of local self-government at village level. Constitutes the first level of governance in the Panchayati Raj system.
Gram Sabha	A body consisting of all persons registered in the electoral rolls of the village.
Gramsakhi	A full-time female Village Health Functionary in the CHCS serving a population of 250.
Gujarati	Language of the people of Gujarat
Hindi	National language of India used more predominantly in the north of the country.
Homeopathy	Alternative system of medicine derived from Germany and practised in India.
Khelwadi	Playgroup
Marathi	Language of the people of Maharashtra
Panchayati Raj	Local self-government

Panchayati Samiti	Rural local self-government institution at the block/sub-district level of approximately 100,000 population. Constitutes the second tier of governance in the Panchayati Raj system.
Raj	A term independently used refers to post 1857 British rule in India.
Sahyogini	An extensively trained local female functionary in the CHCS serving a population of 5000. She bridges the functional gap between the village and the block/taluka level health care facilities.
Shramdaan	Volunteered labour for community benefit for which payment is not accepted.
Tai	Village elder sister(s)
Taluka	Administrative unit for revenue collection covering population of approximately 100,000.

Developing An Alternative Strategy for Achieving Health for All

The ICSSR/ICMR model – The FRCH Experience

The maintenance of physical health and mental well being is probably the most cherished of human requirements. Hence, like preachers and teachers, healers have been the most respected, though not most affluent, members of society. Their remuneration has been the respect and job-satisfaction they have enjoyed. They have provided a personalized service with love and compassion to all regardless of other considerations.

In more modern times, this role has undergone a change. The personalized method of health care has been replaced by a more impersonalized and less effective one. Led by the World Health Organization (WHO), packaged programmes are delivered to people via the health ministries of WHO affiliated countries. This is regardless of the fact that the problems of health and disease vary not only from country to country, but also from region to region and even from village to village. The majority of health problems primarily concern the individual, the family and the local community. Yet the modern system of health care has converted this personalized activity into a commodity to be 'delivered' by an impersonal government, or as a profit-oriented privatized service.

The healing profession has been co-opted by the pharmaceutical and medical industry which sees it as a lucrative business in a field where consumer resistance is at its lowest.

In the process, curative medicine, the money-spinner, has overtaken the far more important preventive and promotive aspects of medicine.

In post-colonial societies, this new form of economic re-colonization has pauperized the masses resulting not only in the regression of people's health but also in the resurgence of communicable diseases - the diseases of poverty.

ALMA ATA AND AFTER

In 1978, at a landmark WHO-sponsored conference in Alma Ata an international declaration that promised 'Health for All' was adopted[1]. It was a strategy of integrated health and medical care for the 'need based' countries, including India, that were signatories to the declaration. Over the years, though, the integrated approach advocated in Alma Ata was converted into a series of vertical programmes based on the bio-mechanical, so called 'scientific' Cartesian concept of life, including health, which provides no space either for spiritualism or altruism, neither of which can be quantified. This approach also disregarded the fact that disease patterns are different in different parts of the world, and that some countries have their own well established, readily accessible, acceptable and cost-effective health culture, practices, and systems of health and medical care.

Privatized, lucrative, western style curative health services, which are increasingly becoming the norm, serve an affluent minority, but ignore basic health and medical care for the majority. This has come about due to excessive pressures of

the pharmaceutical and medical instrumentation industry, which has co-opted the medical profession. This has been forced on developing countries through the Structural Adjustment Policy dictated by the World Bank and the International Monetary Fund.

The major western donors of the World Health Organization, who dominated the world and its resources, co-opted the new leaders of developing countries into the economic strategy of globalization, liberalization and privatization. This widened the gap between developed and developing countries and also between the rich and poor within developing countries.

This has further distorted the health scenario in developing countries where we now have, here in India, the ludicrous situation where five-star hospitals vie with each other to attract 'medical tourists' from the West, even as 85 per cent of the local rural and urban slum population do not have access to basic health and medical care![2] The Indian government promotes and encourages this development arguing that it is a way of earning foreign exchange; but the money earned never trickles down to strengthening the public health service.

As the cost of health care in affluent urban enclaves in our country has increased hugely as a consequence of the above-mentioned policies, a new medical business termed 'health insurance' is now being promoted. Since the way in which insurance works is little understood, few people realize that what claims to make health care affordable can end up further increasing costs[3].

This type of curative medicine which trades in human suffering in an area where consumer resistance is at its lowest, is now the most lucrative and most rapidly growing business and industry in the world, whose tentacles are extending even to the poorest. This form of 'health' care now poses a health hazard to the rich, pauperizes the middle class and is the cause of rural indebtedness next only to dowry.

The reason politicians of developing countries permit and even promote these distortions is because they accepted the Westminster model of representative democracy instead of the far more effective form of participatory democracy that Mahatma Gandhi had strongly advocated. The traditional decentralized form of governance in India viz. *Panchayati Raj* somehow slipped through the political net and was formally institutionalized only by the 73rd and 74th Amendments of the Constitution of India in 1993.

Though it is still opposed by strong vested interests who want to maintain the status quo, *Panchayati Raj* has nevertheless started taking root in various parts of the country as a result of increasing public awareness. Health is one of the 29 subjects allocated to *Panchayati Raj* under Schedule 11 of the Act. If correctly implemented, the *Panchayati Raj* system is the best means of delivering humane and cost-effective health care to those who currently don't get it.

A health care system along these lines has been developed and is being practised in some parts of the country. But before

we go into the details, let us look at some of the health policies postulated in India over the years.

THE BHORE COMMITTEE

In 1943, the Health Survey and Development Committee (popularly known as the Bhore Committee) under the chairmanship of Sir Joseph Bhore, an ICS officer, was commissioned to do a survey of the nation's health. After Independence, the Committee's report was adopted as the blueprint for the National Health Policy. The report provided not only a remarkably detailed picture of the health status of the country in 1946, but also a comprehensive plan for the future development of the health services, from Primary Health Care (PHC) within the local community, to the provision of medical services up to the district level[4]. A brief summing up of the contents of the Bhore Committee report shows how prescient the report was.

- It declared that 'No individual should fail to secure adequate medical care because of inability to pay for it'.
- It put special emphasis on preventive and promotive action for the vast rural population.
- It said that health services should be placed as close to the people as possible to ensure the maximum benefit to the communities to be served.
- It is essential to secure the active cooperation of the people in the development of the health programme. The idea must be inculcated that 'ultimately the health of the individual is

his own responsibility' and in attempting to do so the most effective means would be to provide health education as well as opportunities for active participation in the local health programmes.

- For the scheme to be successful it should be entrusted to 'Ministers of Health' who enjoy the confidence of the people and are able to secure their cooperation.'
- 'The doctor of the future should be a "social physician" protecting the people and guiding them to a healthier and happier life.'
- 'Active support of the people be secured through Health Committees in every village for the improvement of environmental sanitation, control of infectious diseases and other purposes'.

This remarkable report had only one failing: it did not appreciate the value of indigenous medical systems including homoeopathy. Most of the committee members were steeped in western science, a science that had just helped win two major wars. Moreover it was the prevalent way of thinking then, echoed in our own leaders like Jawaharlal Nehru who believed that the development of 'underdeveloped' countries could only be achieved through such a science based approach.

POST- INDEPENDENCE ERA

In the years after Independence the country *did* achieve some remarkable success in its health scenario, fuelled by the vast human power and enthusiasm of the people of a newly independent country supported by committed health officials

and strong political will. It is not widely known that in just 15 years, in the period just after Independence, the four major diseases viz malaria, plague, cholera and small pox were controlled and on their way to being eliminated countrywide. They were already being controlled in the cantonments of the *Raj* where strict rules of hygiene and quarantine were followed. At Independence, this was followed countrywide by motivating people in their own self-interest. The remarkable achievement through concerted political will of those post-independence years in controlling diseases has not been sufficiently recognized and applauded in India or abroad.

Over the years, though, these programmes lost their momentum and the emphasis shifted from a centralized public sector (that provided preventive and promotive health care to all, and basic curative services for the poor who could not afford private services), to an uncontrolled private sector that chiefly served the small affluent section with ability to pay for such services.

The indigenous systems of medicine that are cheaper have also been ignored. While 7,00,000 doctors have been trained in the western allopathic system, and an equal number in *ayurveda* and homoeopathy, the budgetary allocation for the former is 96 per cent, and for the latter, a mere four per cent[5]. While as much as 70 per cent of the population is still based in rural areas, 70 per cent of doctors practice in urban areas.

This clearly demonstrates the perversity of a political culture that permits a small but affluent section of people to decide policies that favour the affluent few against the poverty-stricken

majority. We are informed that even though India is an independent and 'democratic' country, there is no alternative but to follow the increasingly expensive western market oriented model however inappropriate it may be for our people at large! This has led to a reduction in the budget for the public sector, while simultaneously promoting World Bank loans for narrow vertical programmes. This policy, dictated by the IMF as part of its Structural Adjustment Policy, also demands that the private sector be given free rein to dominate the health scene and to charge for its services. This has resulted in four-fifths of the 5 % of GDP allocated for health being appropriated by the private sector[6].

The result is that the five per cent of the population in whom the wealth of the country is concentrated, is dangerously over-medicalized in five-star hospitals, the middle class is pauperized as it tries to follow its wealthier role model, and the poor are forced to rely on an exploitative private sector as the public sector grows increasingly ineffective and unaccountable.

THE ICSSR / ICMR REPORT (1981)[7]

The 1981 ICSSR/ICMR report 'Health for All: An Alternative Strategy' offered a viable alternative to this dismal health scenario, especially for the 85% of Indians who are most in need of such services. The report was based on the social, cultural, economic and epidemiological pattern of the vast majority of our people.

The aim of this far-sighted report, to which some of the

most senior members of the medical and social science(s) professions contributed, was to provide an alternative health care system that was accessible, culturally acceptable and cost-effective for all citizens, especially the poor, and that was accountable to the people it served. It advocated using the People's Sector as anticipated under *Panchayati Raj*. Its salient features were:

- Using inherent self-interest, social skills and face-to-face social accountability of the local community.
- Encouraging people to utilize their age-old health culture and practices together with the best of all available systems provided in a simple and effective manner.
- With the support of the community, this decentralized system could devise a graded training and referral system from the village to the community's own hospital and training complex. This would meet almost 95% of all requirements of health and medical care up to a broad-based medical and surgical specialty level within a 30,000-population level presently serviced by the government Primary Health Centre.

The approach bears some resemblance to the 'barefoot doctors' of communist China. That experiment, it is often said, could only have worked in a dictatorial regime like Mao's China. Yet the experience of several NGOs in various parts of India (including Kerala) and other countries has demonstrated similar achievements since the 1970s under democratic, non-dictatorial forms of governance[8].

The organizational structure of this community health care system consists of distinct functionaries working at different levels of the population: 250 (*Gramsakhi* or Neighbourhood Health Functionary), 5000 (*Sahayogini or Village Health Functionary*) and 30,000 (People's Health Complex)[9]. (Fig.1)

The essence of implementation of this integrated Community Health Care System (CHCS) is the development of a three-tiered model composed of resident village women or neighbourhood functionaries working at the grassroots and providing intensive social interaction since one functionary covers 250-300 population, equivalent to 35 to 50 households. The second and third tier comprises of an upgraded worker covering a population of 1000 and 5000 respectively. This would cover approximately 80% of all health and medical problems at the village level. Fifteen percent of the remaining health issues would be referred to the Community Hospital and Training Centre at the 30,000 PHC level or 100,000 population at the *taluka* level. This would offer appropriate and effective medical and surgical care upto the broad based specialty level, besides continuous training and support for the grassroots workers including a Reverse Referral Service to the village community. This leaves only about 5% of problems requiring highly specialized care, which can be handled by the District level hospital. Such a decentralized system would ensure a strong epidemiological coverage of the country it serves.

Fig.1

Organizational Structure of the Community Health Care System (CHCS)

Approximate Population	Functionary	Responsibility To	Approximate proportion of the total services covered
250	Community Health Functionary	Neighbourhood group	70%
1,000	Village Health Functionary	Gram Panchayat	
5,000	Sahyogini (Referral Centre)	Group Gram Panchayat	85%

Curative | **Training Cell** | **Public Health**

30,000	People's Health Complex	Panchayat Samiti	95%

FRCH'S MANDWA PROJECT[10]

It is this approach that the Foundation for Research in Community Health (FRCH) has followed with considerable success. The Foundation also provided the research and secretariat for the joint ICSSR/ICMR panel, and its field experience has since tried to demonstrate the feasibility, principles and practices that underlie the alternative strategy as defined by the ICSSR/ICMR Report.

As a surgeon in charge of a specialty department of a reputed medical college in Bombay, Dr. N. H. Antia, founder of FRCH had ventured in the early 1970s to try and see how he could help the people of Mandwa - a typical rural community living across the harbour from Bombay. It was obvious that the underlying cause of most health and medical problems that the villagers of this North Alibag area (population of 30,000) faced was poverty, for which he, trained as a doctor, had no solution.

The next best solution that presented itself was to try and teach local residents how to treat the common medical problems that cropped up in their community. Sitting under a tree, the rural equivalent of a conference hall, Dr. Antia and his team traded their theoretical medical knowledge for the local practical knowledge and wisdom of 30 local village women (one per village of about 1000 population). Women were chosen because they comprise 50% of the adult population. They are also more concerned about health issues and more committed than the

menfolk to carrying out any such programme. Besides, women and children under 15 comprise almost 75 per cent of our population and the majority of health problems concern them.

These ordinary village women, whose education level varied from 4th to 10th standard, were trained by FRCH staff in basic health care and concepts and proved to be eager and intelligent learners. To everyone's surprise, they demonstrated that they could achieve within five years, in the mid-1970s, over 70 per cent of the health targets set by the government (based on WHO norms) for the year 2000. These targets included those for controlling waterborne diseases, leprosy, malaria, tuberculosis, ANC, PNC, immunization and family planning.

Similar projects run by voluntary agencies were also in operation in the early '70s in Jamkhed, Miraj, and in Kasa. In 1978, the government's Community Health Workers (CHW) scheme based on such experiences was initiated on a countrywide scale. Over 100,000 workers, 92 per cent of whom were male, were provided an honorarium of Rs.50 per month and given two weeks' training at the local Primary Health Centre (PHC). The scheme was, however, doomed to failure because the government failed to appreciate the crucial elements of selection, continuous training through discussions, implementation and monitoring. Above all, it failed to understand that ownership had to be with the local community; instead, this programme was co-opted into the lowest rung of the government Primary Health Care system, with the aim to provide community participation to achieve the targets set for various vertical

government schemes. It failed to appreciate that primary health care must lie primarily in the hands of the people themselves, not with the government PHCs, whose duty is to provide support but not appropriate what are essentially people's own functions.

The ICSSR/ICMR 1981 Report, which had stressed the people-based approach, had also stated that it would work only if a people-based decentralized form of governance viz. *Panchayati Raj*, came into existence. The Report only provided a theoretical model for implementation wherever possible to demonstrate its feasibility. The Mandwa project[10] demonstrated that it was feasible.

Whilst illustrating that primary health care was essentially a social, community-based activity, the Mandwa project also established certain principles underlying primary health care through a people-centred approach. Simple but cost-effective medical knowledge and technology was effectively utilized together with the local knowledge and wisdom of semi-literate women supported by a simple graded referral system. This could transform the health scene at a remarkably low cost. A new mode of communication, exchange of information and referral system however needed to be developed. Such a method could help bridge the increasing India-Bharat or urban-rural divide and it demonstrated that you did not have to be educated to be intelligent. The experience showed that these health functionaries were concerned and aware of local conditions and problems and were acceptable to their community and hence directly accountable to it.

Less happily, the Mandwa project demonstrated that the political system in a hierarchical society considers such an approach as a threat even in the relatively non-threatening area of health. The health related training of semi-literate village women was perceived as a threat to the power structures in the village and beyond. Ultimately this resulted in the forced termination of this fascinating experiment. Though FRCH withdrew from Mandwa after 10 years, we were satisfied that this was a viable health care approach, which could be successfully replicated.

MALSHIRAS

The experience of Mandwa[10] was followed by a five-year spell attempting to improve primary health care in another rural community, Malshiras, in Purandhar *taluka* of Pune district. As part of this five-year ICMR-supported project on Health Education, FRCH provided education to the staff of a PHC and combined this with direct health education to the people served by the same PHC.

Typically, the government staff showed little interest. Alerting the community to health issues only increased the demand for PHC services and accountability on the part of the staff, which they did not like.

While the community welcomed information, they were not provided the services of trained village women health workers as in Mandwa, nor did they have the support of the PHC. Hence they had to resort to the private sector for expensive and often poor quality curative services[11].

PARINCHE [12, 13]

The experiences of Mandwa and Malshiras led to a further, more systematic, exploration of this people-based approach to health and medical care. The village of Parinche in the Purandhar *taluka* of Pune district was the control area for the Malshiras project and FRCH already had contacts here as well as certain baseline data of the valley and its population. It was only 60 km from Pune, where FRCH now had its main office.

This project named after its main village viz. Parinche is in a valley surrounded by hills rising to 1300 metres and had not been exposed to any major urban influence. With a population of 20,000 covered by 13 *Gram Panchayats*, this valley has two very different terrains. The lower half is chiefly a market gardening community while the upper half consists of very hilly terrain chiefly restricted to the rearing of cattle and production of milk. Despite almost 2500 cm of annual rainfall, there was perennial shortage of water in this hilly terrain for six months of the year, in marked contrast to the well-irrigated lower half. Rented accommodation in the largest village of Parinche served as FRCH's base, from where the majority of the local staff for the project was recruited around 1994.

Based on the Mandwa experience, contact was made with the local community, this time chiefly through street plays. Three doctors were recruited from the three different systems of medicine - allopathy, *ayurveda* and homoeopathy. Unfortunately the doctors soon converted the project into a curative service

by conducting outpatient services, a function for which doctors seem to be almost exclusively trained. This was not how the project had been envisioned, so the doctors were dismissed and the women of the village were recruited as health workers as had been done in Mandwa.

In the early stages, a team of two health educators who had previously worked for FRCH in the tribal schools of Thane district worked here too. They were also engaged in the non-formal education of children in these villages, which led to the production of two highly innovative training manuals in health for children. This helped to introduce the local village health workers to the concept of community health care rather than curative medical care.

The selection and training of 17 *tais* (elder village 'sisters') was conducted by a senior nurse, co-author of this publication who had served as the head of a training school for ANMs in Pune. She evolved a new and highly original approach to the training of these semi-literate, locally resident, married, village women. The women were trained to serve the health needs of 250 people living in about 35 neighbouring households. They were trained to regard their work more as a personalized social function and to treat patients almost as an extension of their own family.

These '*tais*' would meet regularly with the trainer under a tree (or in a temple during the monsoon) in different villages to discuss the problems of their community and to exchange

experiences not only as regards health, but also several other activities. These informal discussions, within the local village setting, on concerns other than health was a radically new approach to health communication. Discussions on the health of their cattle, economic problems of the community and country, education of children, all figured, providing a stimulating and friendly social occasion and environment which encouraged the regular attendance of the *tais* who were only paid their transport cost and reimbursed for their lost daily labour wages.

The women attended the sessions eagerly despite having to contend with household chores, doubts expressed by husbands and in-laws and often having to walk several kilometers to the meetings. They were also exposed to places outside the valley, to learn subjects like veterinary medicine, to see how hospitals functioned and how watershed planning was done. This approach is very different from the formal medical education provided in ANM Schools or Primary Health Centres.

The 17 *tais* we started with, expanded to 50 *tais* in different regions of the valley in two years. This provided intensive house-to-house coverage of a well-defined population of 5,600 at virtually no expense. It also ensured detailed and accurate recording of illnesses and medical expenditure incurred by every household, which provided useful data for future planning.

Selection and Training of '*Tais*'

The '*tai*' selected by FRCH is a neighbourhood functionary who is married, well-settled and acceptable to her community.

She has the necessary motivation, time, ability and desire to serve her immediate community of about 250 persons in about 35 adjacent households. This ensures intensive coverage in a highly personalized and non-formal manner to what she considers is her 'extended family' and friends. She is always available to the community and also accountable to it. She has the ability to mobilize her community for joint action in matters such as water and sanitation that village communities often have to fight for. Because she constantly interacts with members of the community, she can see signs of diseases like tuberculosis at an early stage. Once the diagnosis has been confirmed, she can also ensure that the treatment is continued and provide a superior form of DOTS treatment at virtually no cost. Most of the activities of the National Disease Control Programme, including Family Planning, can be better undertaken and supported by the *tais* because of their ready access to the community as a friend.

- The *tai* has to be a female since 75% of the population consists of women and children below the age of 15 and the majority of health and medical problems concerns this segment of the population.
- Health education of her people is a continuous non-formal function of the *tai.*

This non-formal method of training seated under a tree or in a temple is not only cost-effective, but it is also in keeping with the culture, habits and practices of rural areas. It has proved to be more effective than formal training in classrooms

and much less intimidating. There is no hierarchy between students and teachers as everyone is seated on the floor. The method is chiefly discussion following practical demonstrations provided within the village under the prevailing socio-economic conditions. This helps to evolve highly practical solutions to problems that vary from village to village. There are no preconceived solutions for achieving 'targets' since this would assume, erroneously, that conditions everywhere are the same.

A small group of *tais* comprises of about 15 to 20 women. This encourages active participation of all members. Since the training is given in the village itself on a rotation basis, local problems and the participation of the local community is ensured. Open discussions are held where the local people can also observe and participate. This gives the community greater confidence in their *tais* and support to her from her community is more easily forthcoming.

The training also involves subjects other than health such as veterinary medicine, formation of small savings groups, public information on subjects like *Panchayati Raj* communicated through wall writing, posters and pamphlets, a monthly newsletter produced by the *tais*, *khelwadis* for children, street plays, and involving school children in health activities like testing of water for potability. These have proved to be enjoyable social activities conducted with songs and other entertainment and have provided stimulus and confidence to the *tais* who become informal leaders of their community. Many of these *tais* have become excellent trainers in their own right.

A very crucial element is the integrated manner of training. For example, when teaching about water borne diseases, the politics of water and water conservation would also figure alongside bacteriology. A training session on tuberculosis will integrate clinical TB management with issues of poverty, under nutrition and equity.

At the monthly meetings all the *tais* exchange notes, discuss their experiences including problems affecting the social, economic and even political problems of their communities.

Visits to other centres to discuss, learn and exchange experiences increases the confidence of the '*tais*' who now participate and mobilize women to attend and actively participate in the *Gram Panchayat* meetings.

Informal meetings with a variety of visitors and uninhibited discussions with them have played a useful role in educating and informing the *tais* as well as the visitors. Visitors are often struck by the quiet confidence with which the minimally educated village women speak on matters that extend beyond health and medical care, making this an example of a non-aggressive but highly effective means for women's empowerment and rural development.

Knowledge has given the women strength; they have emerged from the isolation of their gender which restricts them to home bound activities, and their confidence has been boosted as they travel to meetings, discuss mutual problems and evolve new solutions. This can be achieved through any activity that brings

women together such as small savings schemes, income generation projects, veterinary camps etc.

Some of the *tais* are now competent with computers. Basic and upgraded computer programmes in Marathi called 'SYMPMED' (symptomatic medicine), devised by FRCH, are being used at the base station in Parinche to help *tais* in distant locations who can call in for help via mobile hand-sets. They can ask for help in diagnosis or prescribing drugs, emergencies or additional medical information. The first version has been in operation for 11 years and featured in the *British Medical Journal* in 1998[14]. The upgraded version of the telecommunications programme which is currently operated by the *tais* covers more signs and symptoms, includes additional features like pathology and other investigations, danger signs and symptoms, side effects and information on national disease programmes.

The major achievements at Parinche have thus been:

a) The devising of an innovative integrated training content encapsulated into 10 modules in the self-study mode with theoretical and practical components. These modules are used in the 2-year certificate course of the National Institute of Open Schooling, New Delhi for which FRCH is the Accredited Vocational Institute. The modules originally in Marathi have been translated into Hindi and Gujarati.

b) An important outcome of the training has been the significant utilization of the *tais* by the community (55%) as compared

to those of the local public (4%) and private health services (41%) (Fig.2)

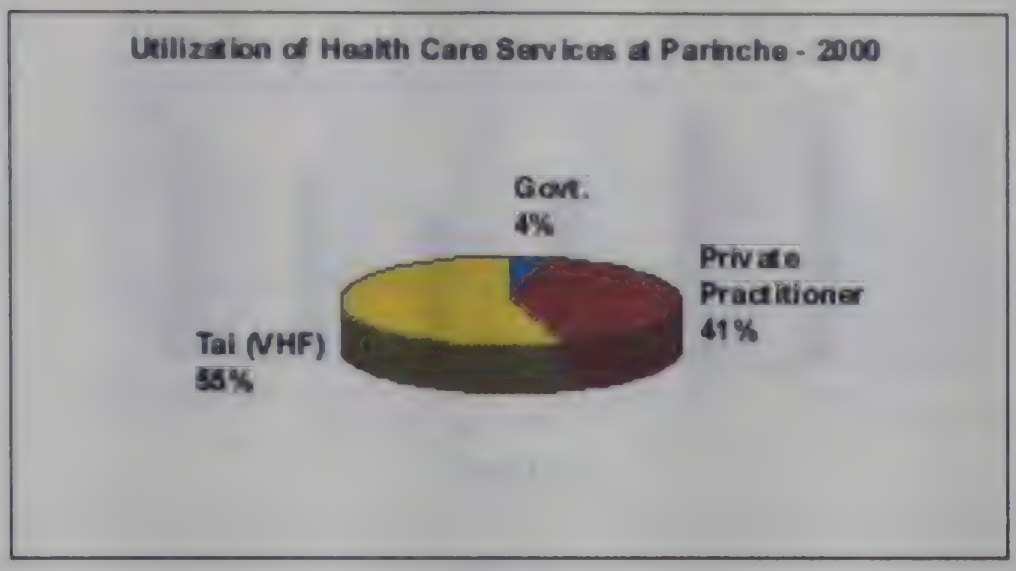


Fig.2

c) The confidence of the community in its health workers is demonstrated in the increased utilization of the services of the *tais* by i) males in the age group of 1-4 years ii) females in the reproductive age group of 15-44 years and beyond (Fig.3) iii) predominant service seeking from *tais* (versus local doctors) from a wide range of 5-64 years (Fig.4)

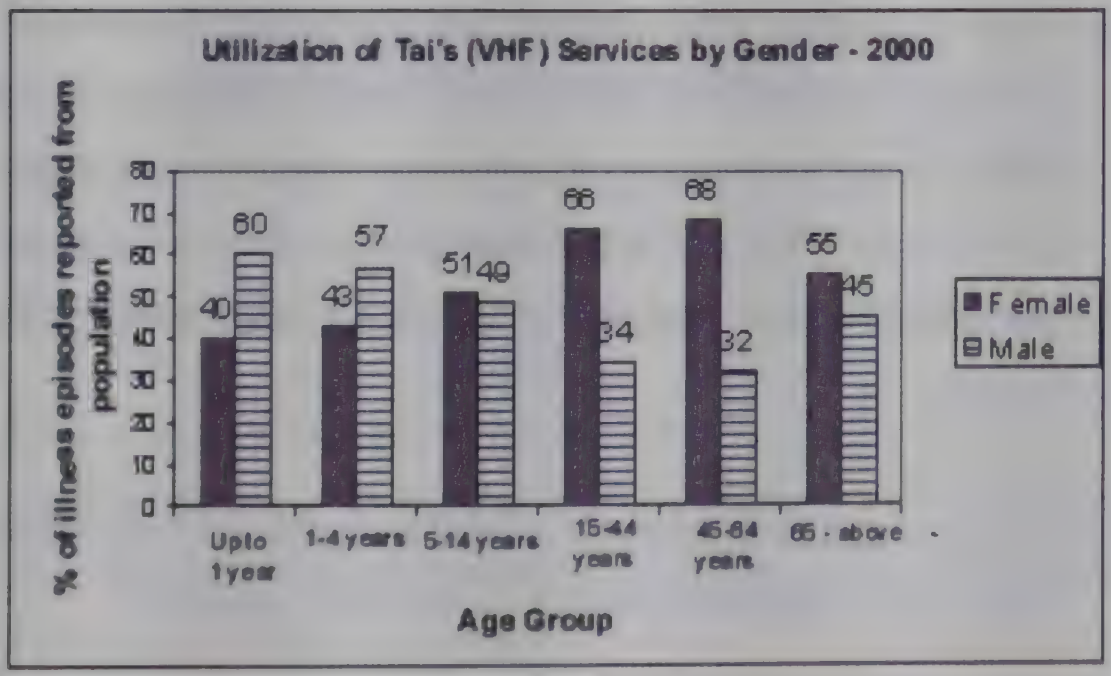


Fig. 3

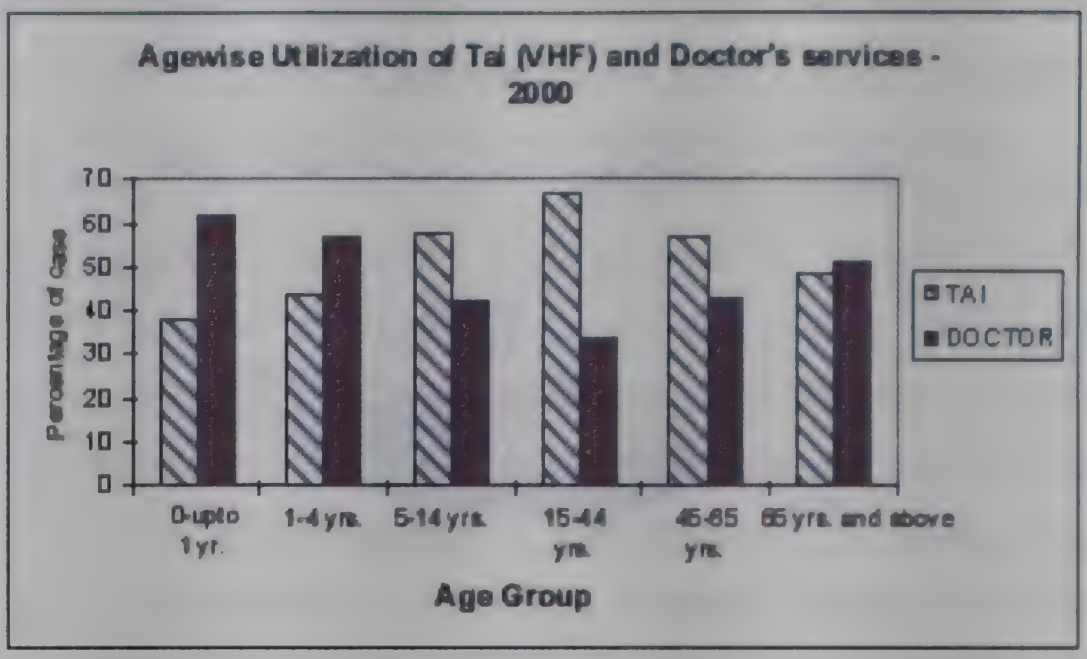
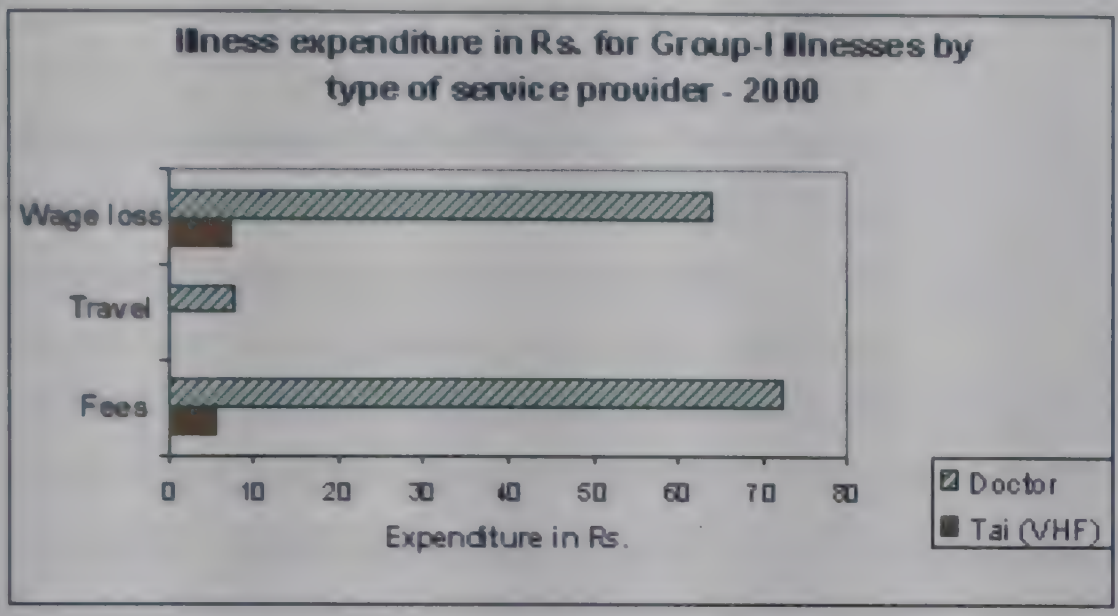


Fig. 4

d) The utilization of health services offered by *tais* has resulted in over 90% savings in health expenditure of common diseases constituting Group I and II of diseases as defined in the lay reporting system of the WHO. (Fig.5)

e) Such outcomes encouraged the European Commission through the Ministry of Health and Family Welfare to provide seed monies for establishing a Resource and Training Centre at Parinche. This has been extensively used for spreading the people-based concept of health to other parts of the country.

f) Fine-tuning of the research component for use in proposed large-scale demonstration-cum-research projects.



Group I: Illnesses comprise of psychosomatic problems which need understanding and explanation rather than a pill or an injection.[15 16]

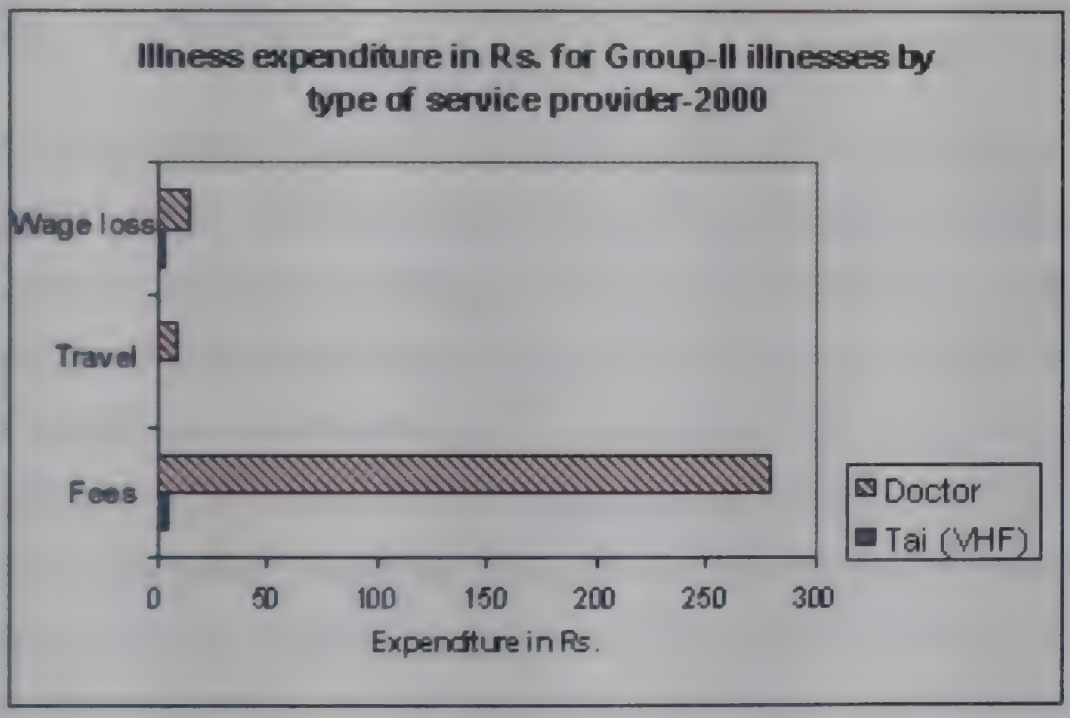


Fig.5

Group II: Illnesses comprise of simple self-limiting diseases which can be adequately handled by the individual and / or the family for e.g. minor coughs, colds, diarrhoea, body ache, headache, cuts, bruises; boils, minor allergies and a host of everyday conditions.[15 16]

FUTURE PLANS

The big question now is: Will Parinche remain just another NGO localized activity supported by donors? The answer can be gauged from the fact that in the eight years the project has been in operation, both the message and the activities have spread to other areas - Chandrapur in Maharashtra, Phulbani in Orissa, Hazira in Gujarat, Patamda in Jharkhand and to West Bengal. With a modest grant from WHO, the *tais* of Parinche, accompanied by a trainer, were able to train 1400 women of a well organized Small Savings Group in this new concept of health in the districts of Ratnagiri and Mahad in Maharashtra.

FRCH made a presentation of its work in Parinche at a meeting in Delhi organized by the Ministry of Family Welfare in the year 2001, which was attended by the Minister of Health and other national and international agencies. After the presentation, the Ministry of Family Welfare requested the European Commission to support FRCH in enlarging its activities by establishing a Resource Centre in Parinche and similar training and resource centres in other states. Requests to set up similar facilities have been received from other states and voluntary agencies not covered by the European Commission.

FRCH now utilizes its Parinche centre for demonstrating the possibility of developing a **PEOPLE'S HEALTH MOVEMENT**, details of which have been described in an FRCH publication titled 'Health and Medical Care: A People's Movement'.[9]

Workshops, demonstration visits as well as short-term and long-term training of individuals and small groups from various regions are part of an ongoing programme. This includes extension of the project to cover the entire Parinche valley and larger adjacent villages like Veer with a population of 6000.

While the Parinche project was started by the FRCH staff, the majority of its activities, including training, is now chiefly undertaken by senior *tais* with more than four years' experience. They participate in training programmes in distant regions, which increases their own self-confidence and also convinces the trainees, who too are village women, that they can also undertake similar programmes.

A major step in disseminating this method of health care occurred when FRCH was accredited as a Vocational Institute (AVI) by the National Institute for Open Schooling (NIOS), Delhi, to organize the training of such health workers on a national scale. FRCH persuaded NIOS to reduce the admission qualification from the tenth standard to the fourth standard, based on its own experience. Only trainees who have the support of an umbrella organization (e.g. NGO, PRI, Government) committed to the cause of a people based form of health care and its dissemination are admitted to the NIOS course. A general approach comprises i) a short orientation of senior functionaries of organizations ii) a 3-month training of their chosen co-ordinators who will facilitate the work of the health workers in their communities iii) Selection and training of the health workers towards NIOS certification iv) creation of a cadre

of local master-trainers in other states who would carry forward local dissemination. Twenty-five first year trainees from the Parinche Project received the National Certificate in March 2004 for the first level of training on passing the examination conducted jointly by NIOS and FRCH.

These *Gramsakhis* will now register with NIOS for a second year *Sahayogini* course for enhanced training, including basic clinical medicine and pathology. The course is being devised and produced by FRCH for the NIOS. This will eventually provide standardized training for village health workers on a national scale certified by the NIOS. There is already a demand in different parts of the country for this type of training.

While such training may not currently provide a strictly legal basis to the grassroots worker, it provides an assurance of competency for the worker from the National Open School which is at the core of the legal guidelines formulated by WHO for functioning of all paramedical workers.

There are two other steps on the ladder to cost-effective rural health care that are in the process of being advocated by FRCH – a third year of training for rural health functionaries, and a supporting Community hospital.

It has been obvious over the years that the failure of the government's PHC health programme for rural areas is due in large measure to the reluctance of doctors and nurses trained in urban colleges to live in and serve rural communities. This is also due to the cultural distance between city reared and

city trained personnel and the rural population. To combat this, a Rural Health Functionary trained for three years who, like a traditional family doctor, can attend to the majority of referral problems is essential. FRCH is exploring the possibility of providing a third year's training to selected *Sahyoginis* under the NIOS programme to fill this void.

The ICSSR/ICMR Report had stated the need for a Community Hospital at the 100,000 population level as an integral part of a comprehensive CHCS. The demonstration projects of the FRCH indicate that the Community Hospital would be more accessible and effective at the 30,000 population level under the community's control. With support sought from the ICMR for the research component, FRCH is in the process of establishing two such comprehensive demonstration projects, one in the non-tribal area of Ralegan Siddhi, and the other in the tribal area of Khiroda in Jalgaon district (both in Maharashtra), each with a population of 30,000 which we feel will provide a better unit for an integrated health care system. In addition to the hospital, there will be a training complex for providing continuous education to all local health functionaries from the village to those serving the hospital.

Such a community-operated and community controlled system, both administratively and financially, can be achieved with the exception of a few doctors and nurses, on a salary scale prevailing at the village level. Many of the village staff will be part-time workers living in their homes. An attached *dharmashala* will take care of the relatives of the patients who

can also participate in the care of the patients.

We project that this self-sustaining health care model can provide free or subsidized care for the genuinely poor at a cost of about Rs.400 per capita per annum, well below the Rs.750 'out of pocket' expenses people in rural areas predominantly spend on private health care. (According to the 52nd round of National Sample Survey).

There is no doubt that the country lacks an effective and affordable health care system to provide health care for all its citizens. The means to acquire this has been outlined in the preceding pages. This strategy provides a decentralized form of health care within the physical and financial reach of all citizens. It can also ensure a uniform standard of health education for all health functionaries throughout the country without the need for force or legal action. It can also bring about change in both the public and private health sectors and correct the present gross imbalance in both manpower and infrastructure so that the needs of all citizens are met in a humane, cost-effective and affordable manner with accountability to the people at every level.

Such a model however requires us to jettison some deeply ingrained beliefs and accept new ideas. It requires that people, and not doctors, hospitals or pharmaceutical companies, should be at the centre of any programme and in charge of any health initiative. The salient points of the new approach are outlined below :

- It is difficult for professionals to differentiate education from intelligence and to accept that semi-literate village women can safely tackle a majority of the problems of health as well as medical care if the knowledge and technology is provided to them in a simple manner that they can understand.
- Health concerns the individual, family and local community.
- It is primarily a social problem, with technology as a support and not the reverse.
- 'Modern' medicine is chiefly concerned with the failure of health, namely disease.
- The role of the people, paramedicals and professionals, needs to be defined at every level.
- If a small yet effective hospital and training centre with adequate medical and surgical facilities is provided for a 30,000 population, the community's own health care system can effectively cater to almost 95% of its health and medical needs at less than half the cost that is presently incurred as 'out of pocket' expenses by the poor.
- This can also be implemented in the urban situation with suitable modifications.
- The advent of *Panchayati Raj* now provides the opportunity to implement the ICSSR/ICMR recommendation of providing Health for All by such an alternative strategy which is firmly rooted in the **PEOPLES' SECTOR**.
- That good health and medical care can be cheap if the profit motive and market forces are eliminated.

The reasons for the projected **cost-effectiveness** of the CHCS are as follows:

- Employment of local personnel at every level to the extent that if feasible, and training them within this system. This reduces the cost of salaries, training, travel and housing since all such staff are recruited and function within their own locality and community.
- Local rental accommodation is used wherever necessary to reduce cost as well as ensuring that the service is closely integrated within the community. It also permits high visibility, ready accessibility, support as well as monitoring by, and accountability to the people.
- Openness of all functions and transactions together with regular support and monitoring by the local community and its Health Committee reduces losses due to corruption and nepotism.
- All salaries and wages are in keeping with the local remuneration of similar workers in the same community and also accountable to them; this prevents problems of unionization and includes termination of services, if necessary. Medicine at this level is demystified to a normal social and technical function as in all other fields.
- Continuous training ensures continuity of work even when new personnel are recruited. Hence the system cannot be held to ransom.
- The entire community has knowledge as well as stake in a system that serves their needs.

- Adequate staff is provided within this system for training as well as transport and communications for emergencies as also for the weekly Reverse Referral Service.
- Using and developing alternative cost-effective technologies.
- Mobilizing local community support such as *shramdaan* at no extra cost for most functions e.g. preventive, promotive and curative with emphasis on the non-medical functions, rather than more expensive external functionaries like contractors as in the present service.
- Use of the more economical folk and indigenous systems of medicine and homeopathy in which preventive and promotive aspects of health care become part of the lifestyle and culture of our people.
- Emphasis on education, prevention, early detection and regular and appropriate treatment can greatly reduce the cost of curative services.
- Reduced cost of transport and loss of earning incurred by the people by utilizing the Reverse Referral Service.
- Bulk purchase of drugs and supplies under generic names at the *taluka* level and its proper accounting, distribution and monitoring.
- All buildings are constructed in local style by local workers, not using contractors. This reduces corrupt practices, reduces cost, ensures better workmanship, easier local maintenance with local materials and labour. Existing structures like the CHC, PHC etc., which belong to the Panchayats, can be incorporated into this system.

- Use of a *dharmashala* to extend hospital services at greatly reduced cost.
- Employment of local personnel enables the ratio of salaries to other expenses to be reduced from 85:15 to 60:40 for the hospital and even 40:60 for the Health and Training components ensuring adequate availability for drugs, supplies, maintenance, repairs, transport etc.
- All personnel are utilized in a multi-purpose manner as far as it is feasible.
- All personnel selected would be those who are in broad sympathy with the terms and objectives of 'Health for All'.
- Emphasis on the Health component i.e. prevention and early detection which reduces the costs of the more expensive and curative services.
- The fee charged for services in such a system is devoid of the profit motive. However, it will be prudent to generate a small surplus for the organization and maintenance as a whole, which may then be appropriately utilized with the consent of all concerned.
- Financial and administrative accountability and control is ensured at every level. Access will be provided to all as regards books of accounts, minutes of meetings, files and records. Financial results will be displayed publicly at periodic intervals. This would ensure transparency and openness and check misuse.
- A decreased load and better utilization of the District and tertiary level medical services. This would help in the reallocation of skewed health resources.

- Ensures reduction and better utilization of the private sector. This is also the most effective way of controlling the charges as well as the quality and quantity of the services of the private sector.
- It would also lead to a marked reduction in the household expenditure on health care which not only includes the cost of medical care but also takes into account the cost of transportation, food, loss of working hours or days as relatives often have to travel long distances with patients to avail of medical care.
- Avoids unnecessary investigations and medication especially in the private sector, thus preventing the poor from diverting scarce resources from food to medicines.
- This approach utilizing village-based health workers offers a new cost-effective approach for early detection and prevention by mobilizing local community resources. It can even provide basic curative care which is available for many of these diseases e.g. Malaria, Tuberculosis, Water-borne diseases and Leprosy.

  This also provides a new approach to Family Planning as a result of intensive interpersonal relationship between the female workers and their community.

Examples of care of major illnesses under the integrated community health care system

MALARIA

Gramsakhi / Sahayogini : (Village level)

Suspicion of malaria based on following symptoms

- Fever with rigors for several days
- Body ache and / or headache
- No other evidence or reason for such fever
- Increased mosquito breeding
- Other similar cases in the locality increases suspicion.

Action:

- Takes a finger prick smear for examination and sends it to the Community Health Centre for microscopy.
- Commences chloroquine treatment + aspirin/paracetamol
- Informs community and involves them in mosquito control
- In case of severe headache, drowsiness or loss of consciousness, refers to *Sahyogini* or directly to the Community Hospital.

Community Health Centre (CHC):

- Report on slide
- Inform community to undertake vector-control
- Inform district health officer
- Treat patient if not controlled by choloroquine
- Emergency admission and treatment when required.

TUBERCULOSIS (TB)

Gramsakhi / Sahayogini: (Village level)

Suspects TB in its early stages especially if she knows the index case and observing the following cardinal symptoms and signs.

- Cough more than 2 weeks
- Sputum with or without blood stain
- Loss of weight
- Loss of apetite
- Low grade fever in evenings.

Action:

- Refers the suspected case to the CHC for sputum examination
- If diagnosed as TB – she collects drugs from CHC and ensures regularity of DOTS.
- Convinces the patient of the need to follow treatment which is provided at home at no cost for nine months even if he/she feels better after a few weeks of treatment.
- Advises the family to take regular treatment to protect the other members of the family and even the community of which the *gramsakhi* is also a part.
- Advises isolation and diet.
- Refers the patient for regular checkup to CHC or for complications of drug therapy or of disease.

She undertakes this as a part of her normal duties and hence avoids the stigma of tuberculosis to the patient.

Community Health Centre (CHC):

- Confirms the diagnosis
- Provides treatment regimen
- Ensures availability of drugs for DOTS and RNTCP
- Follow-up at intervals or if any complications arise.

FAMILY PLANNING

Gramsakhi / Sahayogini: (Village level)

- Provides sex knowledge to adolescent girls and eligible couples
- Advises use of non-terminal methods if only two children till they reach atleast four years of age.
- Advises 'terminal' methods namely sterilization when suitable.
- Ensures care and survival of the children.
- Accompanies and helps the patient for surgery
- Provides post-operative care at home.
- Ensures immunization of children, MCH, RCH etc.

All this in a highly personalized and non-formal manner as a friend, without resort to pressure or force for achieving 'targets'.

Community Health Centre (CHC):

- Ensures need and safety of terminal sterilization
- Provision of non-terminal methods
- Safe abortion if required.
- Ensures safety of institutional delivery
- Advises *gramsakhis* regarding follow-up treatment and care.

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